

Department of Public Health Bureau of Substance Abuse Services, LADC Unit

Department of Public Health
Bureau of Substance Abuse Services/LADC Unit
Attn: Program Coordinator
Donovan Health Bldg
5 Randolph Street, 2nd floor
Canton, MA 02021-2353

COMPLAINANT:

'Name: Last Na	ame		First Name		M.I.
Address:					
Address.	Number	Street			Daytime Phone
	City		State	Zip Code	Evening Phone
Best way to re	each you: Ev	ening Phone D	aytime Phone	E-Mail:	
lf filing for on on			- th	. For the carry imption	
if filing for an org	ganization, a pers	son snall be named a	s the representative	for the organization.	
Organization	Name:				
SUBJECT	(use separ	ate form for e	each license	d individual):	
	(aloo oopan				
Namo:					
Name: Last Na	ame		First Name		M.I.
Address:					
Not required)	Number	Street			
	City		State		Zip Code
	•				•
Where did this	s alleged incid	lent take place?			
THOIC GIG LIN	- unogou more	ioni tano piaco:			
f known, ple	ase check th	e level of licens	sure held by lice	ensed individual	:
_icensed Alco	ohol and Drug	Counselor I (LA	DC I)		
_icensed Alco	ohol and Drug	Counselor (LAD	C II)		
	_				
icensed Alco	hol and Drug	Counselor Assis	tant (LΔDCΔ)		

DESCRIPTION OF THE COMPLAINT: Briefly describe the incidents that led to your complaint and note the times and dates that events occurred. List the names of all individuals involved. Please attach additional pages if needed. (Please use a separate sheet if necessary. Please do not write in the margins.) Additional information or materials attached __Yes __No To speed up processing your complaint, please submit legible copies (not the originals) of all relative documents supporting your complaint (i.e. contracts, medical records, cancelled checks, etc.). You will receive an acknowledge letter indicating we have received your complaint. **AUTHORIZATION FOR RELEASE OF RECORDS AND REFERRAL OF COMPLAINT** My signature to this form, or a photocopy thereof, authorizes the Department of Public Health to: (1) receive copies of all substance abuse, medical and mental health records relating to my complaint, and (2) to refer my complaint to other appropriate law enforcement authorities to investigate and/or prosecute my complaint if necessary. I attest that the information provided is true, correct and complete to the best of my knowledge. Complainant Signature Date (PLEASE DO NOT WRITE BELOW LINE.) If you need assistance completing this form or have questions about the complaint process please contact: Alexandria Kearns, Program Coordinator 781-828-8648 Lucille Nunes, Assistant Program Coordinator 781-828-8046 Michael Morini, Compliance Officer 781-828-7910 Nathaly Diaz, Compliance Officer 781-828-7961 Date Received (stamp): Entered into the Database (Date) ___ /___ /___ Docket #:____-

Signature:

Acknowledgement letter sent (Date): ____/__/